New Jersey Department of Human Services
Adult Day Services Program for
Persons with Alzheimer's Disease or Related Disorders
PO Box 807
Trenton, NJ 08625-0807

DISCHARGE INFORMATION

Name of Agency	
Name of Client	Social Security Number

1. Reason for Client's Discharge from Program *(Check up to 3)* (1) ____ ____

00 ☐ Dementia Progression
01 ☐ Other Illness/Accident
02 ☐ Incontinence
03 ☐ Inappropriate Behavior
04 ☐ Extended Absence
05 ☐ Financial Ineligibility
06 ☐ Relocation
07 ☐ Client Refusal to Attend
08 ☐ Death
09 ☐ Other (Specify): _____
10 ☐ Family Choice
11 ☐ Caregiver Illness/Stress
12 ☐ Caregiver Death

Transfer to Other Funding Source:
13 ☐ Medicaid
14 ☐ MLTSS
15 ☐ Peer Grouping
16 ☐ Respite
17 ☐ SSBG
18 ☐ Jersey Care
19 ☐ JACC

2. Duration of Day Care Attendance (2) ____ ____

00 ☐ 0 - 3 Months
01 ☐ 3 - 6 Months
02 ☐ 6 - 12 Months
03 ☐ 1 - 2 Years
04 ☐ 2 - 5 Years
05 ☐ Over 5 Years
06 ☐ Ongoing

3. Client Was Discharged To: (3) ____ ____

00 ☐ Home
01 ☐ Assisted Living Facility
02 ☐ Residential Health Care Facility
03 ☐ Long Term Care Facility
04 ☐ Acute Care Hospital
05 ☐ Not Applicable
06 ☐ Other Day Care

4. Last Date Client Received Alzheimer's Adult Day Care Funds (4) ____ / ____ / ____

(Month/Day/Year) _____ / _____ / _____

5. Total Alzheimer's Adult Day Care Funds Billed to DHS for Client's Care During Current Fiscal Year: (5) $ _____

$ _____

Name of Agency Representative	Title
Signature	Date

Distribution: Original - NJDHS Copy - Agency